MEDICAL REVIEW – SOUTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE DENTAL AUDIT OF

Liberty Dental Plan of California, Inc.

2021

Contract Numbers:	12-89343 13-90117
Audit Period:	July 01, 2019 Through June 30, 2021
Report Issued:	November 23, 2021

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I. INTRODUCTION

Liberty Dental Plan of California, Inc. (Plan) has a Contract with the California Department of Health Care Services (DHCS) to provide dental services to members in Sacramento and Los Angeles Counties. The Plan has a license in accordance with the provisions of the Knox-Keene Health Care Service Plan Act of 1975.

The Plan is a specialty health plan with its own statewide network of contracted general and specialty dental providers. The Plan has provided dental services for Sacramento Geographic Managed Care (GMC) and Los Angeles Prepaid Health Plan (PHP) programs since 2005.

The Plan has approximately 185 general providers and 59 specialists for Sacramento County and has approximately 864 general providers and 195 specialists for Los Angeles County as of June 2021.

The Plan currently serves Medi-Cal members in California. As of June 2021, the Plan's membership was composed of 184,062 GMC and 70,263 PHP members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of DHCS dental audit for the review period of July 1, 2019 through June 30, 2021. The review was conducted from July 06, 2021 through July 16, 2021. The audit consisted of document review, verification studies, and interviews with the Plan's personnel.

An Exit Conference with the Plan was held on October 27, 2021. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The findings in the report reflect the evaluation of all relevant information received prior to and after the Exit Conference.

The audit evaluated four categories of performance: Utilization Management, Access and Availability of Care, Members' Rights, and Quality Management.

The summary of the findings by category follows:

Category 3 – Access and Availability of Care

The Plan did not effectively monitor provider compliance with the timeliness standards for members to obtain various types of appointments. The providers self-reported the appointment wait time data, and the Plan did not validate and evaluate them to determine actual compliance.

The Plan did not effectively monitor provider compliance with office wait times.

The Plan did not effectively monitor providers' compliance with telephone wait times. This is a repeat finding.

Category 4 – Member's Rights

The Plan sent grievance resolution letters to members without adequate investigation and resolution. This is a repeat finding.

Category 5 – Quality Management

The Plan did not ensure that all providers received training regarding the Medi-Cal Dental Managed Care program. The Plan's policy requires only the office manager, treatment coordinator, and any additional office staff to attend the orientation/training. The policy allows an option for the dentist provider not to attend.

The Plan did not ensure that new providers completed the Medi-Cal Dental Managed Care training within ten business days. The Plan could not substantiate when and what part of the training new providers received. This is a repeat finding.

III. SCOPE/AUDIT PROCEDURES

SCOPE

DHCS Medical Review Branch conducted this audit to ascertain whether the dental services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's GMC/PHP Contract.

PROCEDURE

The review was conducted from July 6, 2021 through July 16, 2021. The audit included a review of the Plan's Contract with DHCS, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed, and interviews were conducted with the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 21 prior authorization requests (denied) were reviewed for consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

Prior Authorization Appeals: 14 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Quality of Care Grievances: 12 quality of care grievances, including six potential quality issue files, were reviewed for a timely resolution, response to the complainant, and submission to the appropriate level for review.

Quality of Service Grievances: seven quality of service grievances, six exempt grievances, and eight inquiries were reviewed for timeliness and appropriate resolution.

Category 5 – Quality Management

New Provider Training: 15 new provider-training records were reviewed for timely Medi-Cal Dental Managed Care program training.

A description of the findings for each category is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Liberty Dental Plan of California, Inc.
AUDIT PERIOD: July 1, 2019 through June 30, 2021 **DATE OF AUDIT: July 6, 2021 through July 16, 2021**

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE	
3.1	**APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES**

3.1.1 Appointment Wait Time Monitoring

The Plan shall establish acceptable accessibility standards in accordance with the California Code of Regulations (CCR), Title 28, section 1300.67.2. The Plan shall communicate, enforce, and monitor providers' compliance with these standards. *(Contract, Exhibit A, Attachment 11(B))*

The Plan shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices for scheduled appointments, telephone calls (to answer and return), and time to obtain various types of appointments above. *(Contract, Exhibit A, Attachment 11(B) 2)*

The Plan shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices for scheduled appointments, telephone calls (to answer and return), and time to obtain various types of appointments above. *(Contract, Exhibit A, Attachment 11(B) 2)*

The following standards shall apply:

- Initial Appointment – within four weeks
- Routine Appointment (non-emergency) – within four weeks
- Preventive Dental Care Appointment – within four weeks (*Contract, Exhibit A, Attachment 11(B)*)

Each health care service plan shall have a documented system for monitoring and evaluating the accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. *(CCR, Title 28, section 1300.67.2(f) Accessibility of Services)*

Finding: The Plan did not effectively monitor provider compliance with the timeliness standards for members to obtain various types of appointments. The providers self-reported the appointment wait time data, and the Plan did not validate and evaluate the data to determine actual compliance.

The Plan's *Access and Availability Guidelines* (effective 12/18/2020) stated that the Plan's Access & Availability Committee conducts ongoing monitoring of provider

compliance with timely access standards through periodic office reviews, accessibility surveys, member satisfaction surveys, and complaints/grievances.

During the interview, the Plan stated that its access wait times monitoring processes are as follows;

- The Plan conducted periodic in-person or phone surveys to monitor providers' appointment, telephone, and office wait times through the Provider Service Report (PSR) survey; however, the Plan did not validate these access wait times data that providers self-reported. The Plan provided documentation for seven providers whom it deemed as non-compliant with access wait times. The Plan did not have documentation to substantiate how the Plan determined, computed, or validated the self-reported wait times from the provider. In addition, for two non-compliant provider offices, the PSR could not identify which particular provider it was monitoring because there were multiple providers listed in the report.

- The Plan conducted the Member Satisfaction Survey to validate appointment wait times. The Plan stated that *Member Satisfaction Survey* (the audit period from July 2019 to June 2021) was sent to 43 members. However, only eight members responded to the survey. The limited survey response could not validate or evaluate provider compliance with access standards as member responses did not relate to or identify any particular provider.

- The Plan also stated that it monitored access wait times compliance through its *Quality Assurance Reviews* for contracted providers. The California Association of Dental Plan (CADP) Certified Reviewers assessed and identified if appropriate care is delivered to members. The Plan provided the Facility Audit Tools for five providers where the reviewer checked off the options indicating that the providers met the various required appointment wait times. The Plan could not provide documentation to substantiate how the CADP reviewers computed or determined the appointment wait times for these five samples.

The Plan's *Access and Availability Committee Minutes* did not provide or evaluate the access-monitoring results for the Member Satisfaction Survey and the CADP Quality Assurance Reviews to validate the self-reported data from the PSR. The Plan did not present or evaluate any access standards issues regarding the appointment, telephone, and office wait time data for access-related grievances in the committee meeting minutes.

Without validating and evaluating accurate provider compliance data for appointment wait times, the Plan cannot identify or address any provider non-compliance with

appointment wait time standards. Non-compliance in accessing timely appointments can result in compromised health or preventable complications.

Recommendation: Develop and implement procedures to effectively monitor providers' compliance with appointment wait times.

3.1.2 Office Wait Times

The Plan shall establish acceptable accessibility standards in accordance with the CCR, Title 28, section 1300.67.2. The Plan shall communicate, enforce, and monitor providers' compliance with these standards. *(Contract, Exhibit A, Attachment 11(B))*

The Plan shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices for scheduled appointments, telephone calls (to answer and return), and time to obtain various types of appointments above. *(Contract, Exhibit A, Attachment 11(B) 2)*

Each health care service plan shall have a documented system for monitoring and evaluating the accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. *(CCR, Title 28, section 1300.67.2(f) Accessibility of Services)*

The Plan's *Access and Availability Guidelines* (effective12/18/2020) stated the standard wait time for in-office appointments was not to exceed 30 minutes, and offices must maintain records indicating member appointment arrival time and the actual time provider saw the member.

Finding: The Plan did not effectively monitor provider compliance with office wait times.

The Plan's *Access and Availability Guidelines* (effective 12/18/2020) stated that their Access & Availability Committee conducts ongoing monitoring of provider compliance with timely access standards through periodic office reviews, accessibility surveys, member satisfaction surveys, and complaints/grievances.

During the interview, the Plan stated that its access wait times monitoring processes are as follows;

- The Plan conducted periodic in-person or phone surveys to monitor providers' appointment, telephone, and office wait times through the PSR survey; however, the Plan did not validate these access wait times data that providers self-

reported. The Plan provided documentation for seven providers whom it deemed as non-compliant with access wait times. The Plan did not have documentation to substantiate how the Plan determined, computed, or validated the self-reported wait times from the provider. In addition, for two non-compliant provider offices, the PSR could not identify which particular provider it was monitoring because there were multiple providers listed in the report.

- The Plan conducted the Member Satisfaction Survey to validate office wait times. The Plan stated that *Member Satisfaction Survey* (the audit period from July 2019 to June 2021) was sent to 43 members. However, only eight members responded to the survey. The limited survey response could not validate or evaluate provider compliance with access standards as member responses did not relate to or identify any particular provider.

- The Plan stated that it monitored access compliance through grievance. A verification study determined that the Plan did not monitor or further investigate the office wait time issues for two access-related grievances. In both cases, the Plan's resolution letter to members indicated that it could not confirm or verify that there were long or excessive office wait times despite the Plan's policy requiring providers to record members' arrival time for the appointment and the actual time the provider sees the member.

The Plan's *Access and Availability Committee Minutes* did not provide or evaluate the access-monitoring results for the Member Satisfaction Survey to validate the self-reported data from the PSR. The Plan did not present or evaluate any access standards issues regarding appointments, telephone, and office wait time data for access-related grievances in the committee meeting minutes.

Without monitoring and investigating provider records for office wait times, the Plan cannot determine which individual providers did not comply with office wait time requirements. This non-compliance may result in members not having timely appointment access.

Recommendation: Develop and implement procedures to effectively monitor providers' compliance with in-office waiting times.

3.1.3 Telephone Wait Times

The Plan shall establish acceptable accessibility standards in accordance with the CCR, Title 28, section 1300.67.2. The Plan shall communicate, enforce, and monitor providers' compliance with these standards. *(Contract, Exhibit A, Attachment 11(B))*

The Plan shall develop, implement, and maintain a procedure to monitor waiting times for telephone calls (to answer and return). *(Contract, Exhibit A, Attachment 11(B) 2)*

Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. *(CCR, Title 28, section 1300.67.2(f) Accessibility of Services)*

The Plan's *Access and Availability Guidelines* (effective 12/18/2020) stated the standard wait time for telephone answers was within 30 seconds. Return Telephone Call was within 30 minutes and specialist appointments was within 30 days of referral.

Finding: The Plan did not effectively monitor providers' compliance with telephone wait times. **This is a repeat finding of the prior year's finding 3.1.3 Telephone Wait Times.**

The Plan's *Access and Availability Guidelines* (effective 12/18/2020) stated that the Plan's Access & Availability Committee conducts ongoing monitoring of provider compliance with timely access standards through periodic office reviews, accessibility surveys, member satisfaction surveys, and complaints/grievances.

During the interview, the Plan stated that its access wait times monitoring processes are as follows;

- The Plan conducted periodic in-person or phone surveys to monitor providers' appointment, telephone, and office wait times through the PSR survey; however, the Plan did not validate these access wait times data that providers self-reported. The Plan provided documentation for seven providers whom it deemed as non-compliant with access wait times. The Plan did not have documentation to substantiate how the Plan determined, computed, or validated the self-reported wait times from the provider. In addition, for two non-compliant provider offices, the PSR could not identify which particular provider it was monitoring because there were multiple providers listed in the report.

- The Plan conducted the Member Satisfaction Survey to validate the telephone

wait times. The Plan stated that *Member Satisfaction Survey* (the audit period from July 2019 to June 2021) was sent to 43 members. However, only eight members responded to the survey. The limited survey response could not validate or evaluate provider compliance with access standards as member responses did not relate to or identify any particular provider.

The Plan's *Access and Availability Committee Minutes* did not provide and evaluate the access-monitoring results for the Member Satisfaction Survey to validate the self-reported data from the PSR. The Plan did not present or evaluate any access standards regarding appointments, telephone, and office wait time data for access-related grievances in the committee meeting minutes.

Without monitoring telephone wait times, Plan members might fail to communicate requests for needed treatment, resulting in members not having timely appointment access.

Recommendation: Develop and implement procedures to effectively monitor providers' compliance with telephone wait times for member calls to the provider's offices.

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CATEGORY 4 – MEMBER'S RIGHTS	
4.1	**GRIEVANCE SYSTEM**

4.1.1 Grievance Resolution letters

The Plan shall implement and maintain a member grievance system in accordance with CCR, Title 28, section 1300.68. The Plan shall resolve each grievance and provide notice to the members as quickly as the member's dental condition requires, or no later than 30 calendar days from the date the Plan receives the grievance. *(Contract, Exhibit A, Attachment 15, A)*

"Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the Plan's grievance system, including entities with delegated entities. *(CCR, Title 28, section 1300.68(a)(4))*

The Plan shall continue to comply with the state's established timeframe of 30 calendar days for grievance resolution. "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance as delineated and existing state regulations. *(Dental All Plan Letter 17-003, E.III.C.2)*

Finding: The Plan sent grievance resolution letters to members without adequate investigation and resolution. **This is a repeat finding of the prior year's finding 4.1.1 Grievance Resolution Letters.**

Plan Policy *Grievances Process California* (effective 12/18/2020) stated that the Plan collects the necessary information to evaluate each grievance properly. The grievance analyst is required to review all submitted information to resolve the complaint and issue a resolution letter. In addition, the analyst is required to prepare a comprehensive file for review that includes, but is not limited to, chart notes, x- rays, consent forms and other information collected from the dental offices, any documentation submitted by the member (or designee), and any Plan documentation or information that the Grievances and Appeals analyst determines would be helpful in the review of the grievance.

After the 3rd quarter of 2020, the Plan introduced a new quality assurance process due to the prior audit corrective action process. In this review, the Plan picked only five percent of all completed grievances to review and ensure that the grievance cases were appropriately resolved.

In a verification study, it was found that the Plan did not ensure collection and receipt of

any documents from the provider for four grievance cases, but sent the resolution letter to the members without further investigation and resolution.

For example:

- A member complained about a provider's quality of treatment. The member had been to the office five times and was still not able to complete their root canal.

- A member complained about access, availability, and quality of service issues with their provider office. The member said the office manager went back and forth in taking x-rays and answering the office phone. The member also stated that the office would submit a pre-authorization request. However, when the member called the Plan, they were told there was no pre-authorization request on file.

In both examples, the Plan did not receive any requested information from the provider. The Plan did not conduct further investigation or resolve the issue. However, the Plan sent a resolution letter to the member, stating that the Plan could not verify the information, as they did not receive any information from the provider.

Resolution letters sent to members without actually resolving the issues could lead to inadequate grievance investigations and resolutions. This non-compliance could also lead to a delay in proper care for members.

RECOMMENDATION: Develop a system to properly investigate and resolve the grievance before sending the resolution letter.

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CATEGORY 5 – QUALITY MANAGEMENT	
5.2	**PROVIDER QUALIFICATIONS**

5.2.1 Plan's New Provider Training Policy

The Plan shall ensure that all providers receive training regarding the Medi-Cal Dental Managed Care program in order to operate in full compliance with the Contract and all applicable federal and state statutes and regulations. The Plan shall ensure that provider training relates to Medi-Cal Dental Managed Care services, policies, procedures, and any modifications to existing services, policies, or procedures. Training shall include methods for sharing information between the Plan, provider, member, and other healthcare professionals. The Plan shall conduct training for all providers within ten business days after the Plan places a newly contracted provider on active status. *(Contract, Exhibit A, Attachment 9(E))*

Finding: The Plan's policy did not ensure that all providers receive training regarding the Medi-Cal Dental Managed Care program. The Plan's policy only requires the office manager, treatment coordinator, and any additional office staff to attend the orientation/training. The policy allows an option for the dentist provider not to attend.

The Plan's *Provider Orientation Policy* (effective 8/4/2020) stated the orientation/training should, at a minimum, include the office manager and treatment coordinator (dentist if possible) and any additional office staff members for whom a full understanding of the Plan may be beneficial.

The Plan's policy has to meet the Contract requirements to provide quality services according to Medi-Cal Dental Managed Care program requirements. Without aligning the Plan's policy with the Contract requirement for new provider training, the Plan risks having untrained providers rendering the services on their behalf.

Recommendation: Ensure Plan's policy requires dental providers to receive training regarding the Medi-Cal Dental Managed Care program.

5.2.2 Plan's Monitoring of New Provider Training

The Plan shall ensure that all providers receive training regarding the Medi-Cal Dental Managed Care program in order to operate in full compliance with the Contract and all applicable federal and state statutes and regulations. The Plan shall ensure that provider training relates to Medi-Cal Dental Managed Care services, policies,

procedures, and any modifications to existing services, policies, or procedures. Training shall include methods for sharing information between the Plan, provider, member and/or other healthcare professionals. The Plan shall conduct training for all providers within ten business days after the Plan places a newly contracted provider on active status. *(Contract Exhibit A, Attachment 9, E)*

Finding: The Plan did not ensure that new providers completed the Medi-Cal Dental Managed Care training within ten business days. The Plan could not substantiate when and what part of the training the new provider received. **This is a repeat finding of the prior year's finding 5.2.1 New Provider Training.**

The Plan's *Provider Orientation Policy* (effective 8/4/2020) indicated that a provider shall have an onsite facility visit prior to becoming effective on the network and conduct an initial orientation for all new providers, but no more than ten days of activation in California.

Plan's policy further allowed an orientation to be conducted via a call, a visit, or webinar depending on the urgency and specific line of business requirements. The Plan indicated that the network manager would conduct the in-person onsite facility review, including training and orientation with an office manager and other key staff. The network manager would use the PSR as one of the tools to document and track the completion of the new provider training. The Plan indicated some dental offices were impacted by the pandemic and shut down. The Plan provided its new provider training through an online webinar only.

For an online webinar, Plan sent a Welcome Letter along with a standard web link and password for its newly contracted providers to access a two-module online webinar training. After completing the second module, the new provider was expected to click an attestation button to certify and date the completion of the new provider training. However, the Plan stated that during the audit period it lacked the procedure requiring providers to click or certify the training was completed.

In the verification study, 15 sampled new providers did not receive training within ten business days. The Plan could not provide documentation to substantiate when all 15 sampled providers received the training. For two sampled providers, the Plan provided only the PSR, which indicated the date an orientation was given to a provider office. However, the PSR did not indicate what part of the training was completed or which new provider received it. For the 13 sampled providers, the Plan only provided the Welcome Letter, but there was no documentation of when or what part of the training the new provider received.

Without receiving training on Medi-Cal Dental Managed Care requirements within the required time frame, the new providers may not operate in full compliance with the Contract requirements.

Recommendation: Develop and implement a process to monitor and ensure the timely completion of new provider training.